Psychological Correlates of Gender Equality among Locomotor Disabled Persons

A Synopsis

For the PhD Thesis

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Department of Applied Psychology

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Introduction

A patriarchal society is inherently biassed towards one gender over another. Currently, patriarchy is the foundation of the majority of societies worldwide. In many ways, it is a type of denigration of women. A girl kid has always been viewed as an undesirable thing and a burden that the parents would not mind getting rid of. Women are discriminated against from the moment of their birth. Gender discrimination is any denial of equality, gender, or opportunity based on a person's gender. India's male-dominated society instills this discrimination in its women as a habit. Because of this, the majority of women are unaware of their own independence and rights.Gender equality in India is a complex and multifaceted issue. Gender equality among people with disabilities, particularly women and girls, is a critical issue that requires attention and action. Women with disabilities face double discrimination due to their gender and disability status, leading to significant disparities in various areas.
Key Challenges:

Health and Healthcare: Women with disabilities are three times more likely to have unmet health needs and experience higher rates of sexual violence, with some estimates suggesting they are up to ten times more likely to be victims of sexual violence.

Education and Employment: Women are discriminated against even before they Compared to males without disabilities, women with disabilities are twice as likely to be employed or use the internet, and they are three times more likely to be illiterate. Just 20% of women with disabilities work full-time in the EU.

Violence and Abuse: Women with disabilities face a higher risk of violence, abuse, and exploitation, with limited access to justice and support services.

What is Disability?

A physical or mental health issue that impairs a person's ability to do daily tasks is referred to as a disability (WHO, 2011). According to WHO estimates, there are already more than one billion people with impairments (WHO, 2011).

What is a Locomotor Disability?

According to the Gazette of India (2024). "Locomotor disability" refers to a condition in which a person's musculoskeletal, neurological, or both systems are affected, makin g it

difficult for them to perform specific actions related to moving themselves and items.Locomotor disabled are different from the normal due to the special characteristics of their disability, due to this difference, the constraints during interaction or other daily activities while living in society and the psychological effects felt due to those constraints are understood. The present research is an effort in this regard for the welfare of the human world.

Types of Locomotor Disability

There are several types of locomotor disability according to the Ministry of Law and Justice (2016).

Locomotor disability including

1. Cerebral palsy
2. Leprosy cured
3. Dwarfism,
4. Acid Attack victims
5. Muscular dystrophy, etc

Acceptance of Disability

The ability to experience ideas and feelings without allowing them to affect one's behaviour is referred to as acceptance. Regarding disability, the theory emphasises how important it is to believe in one's own abilities in order to adjust psychologically (Dembo, Leviton, & Wright, 1956). Psychological adjustment is associated with disability approval .There are two types of disability acceptance: public acceptance and self-acceptance. of disability. Self-acceptance of disability is linked to improved adjustment to disability, allowing them to control, connect, and integrate disability into their lifestyle, so improving their quality of life (Kaur & Tan, 2018). The degree to which an individual (a) acknowledges values other than those that directly conflict with their disability; (b) downplays the aspects of their physical appearance and ability that contradict their disabling condition; (c) does not extend their handicap beyond their physical impairment to other aspects of their functioning self; and (d) does not compare themselves to others in the areas of limitation are all indicators of their level of acceptance of disability (Dembo, Leviton, & Wright, 1956).

Alternatively, Disability acceptance in the workplace and in the general population is associated with friendship, social inclusion, stereotype breakdown, a sense of belonging, and the formation of equal status relationships, all of which can help to reduce stigma and

discrimination. Acceptance of disability can be linked to demographic variables, self-esteem, and social support, as these factors have a significant impact on integrating PWDs into mainstream society. PWDs' perceptions of disability acceptance provide insight into the psychological aspect that determines their entire life circumstances, adaptation process, degree of confidence, and socialization process (Kaur & Tan, 2018).

Studies on disability acceptance are frequently investigated in medical and psychological fields in order to develop effective rehabilitation strategies. Self-acceptance of handicap has been connected in certain research to demographic variables. According to a study, self-acceptance of disability is correlated with a number of demographic traits, such as age, income, marital status, congenital disability, and self-esteem.Both younger and married respondents reported better adjustment to handicap. According to Li and Moore (1998), respondents with higher family incomes were more likely to accept impairment favourably than those with lower incomes.with higher family incomes were more inclined to accept disability favorably than those with lower incomes (Li & Moore, 1998). Woodrich and Patterson's (1983) studies on spinal cord injuries PWDs discovered that self-acceptance of disability and education was strongly correlated with age, gender, and education.As a result, they became more adaptable, driven, and capable of managing and integrating their impairment into their lives**.**

Hosain, Atkinson, and Underwood (2002) state that the general According to Hosain, Atkinson, and Underwood (2002), the public either disapproves of or is unduly Compassionate to people with disabilities.

According to a different survey, neighbours did not want residents with significant intellectual disability to live there close to them because they perceived them as a threat to their safety (Alphen et. al., 2012). Researchers investigated the development of friendship and equal status relationships with 'able-bodied' individuals and discovered that mutuality and acceptance facilitated PWD friendship (Nunkoosing & John, 1997).

It was found that Despite proof, people with disabilities face discrimination, harassment, and unfair treatment at work. showing they are more devoted and perform similarly to 'able-bodied' coworkers. PWDs are negatively impacted by the stigma associated with being unattractive. Because they do not want to lose employees because they do not understand PWDs, employers are likewise reluctant to hire PWDs. Consequently,

To preserve their professional image, many PWDs conceal their handicap. Coworkers and employers that have an unfavorable attitude toward people with disabilities are either excluding them causing individuals to struggle to adapt at work or the labour market (Shigaki et al., 2012).

According to some research, PWDs with lower qualifications face a low level of societal acceptance of their handicap in addition to inadequate infrastructure and support networks (Kaur & Tan, 2018).
Social support has been identified as an important aspect of handicap adjustment. It was found that patients with Compared to patients without aid, those with family support adapted to their impairment more easily (Miller, 1986).

It was found that personality qualities such as agreeableness and openness to experience influence the appropriateness of adjustments for employees with impairments. Colleagues with high agreeableness and openness to experience are more accepting of accommodations made for the employee with a disability than those with poor scores on these characteristics (Garcı́a et al., 2005).

Body image

The image of one's own body in one's mind is called body image, which includes the attitude formed based on feelings, acceptance and experiences about one's body, how positive one is about one's body, how much importance one gives to oneself, body image is also the main point behind the production of self-love. If someone is very dependent on his daily routine, then he may get indifferent towards his body because of this also because he is not able to feel independence, so it is natural that if positive feelings are associated with the body, then a positive body image should be formed. If due to one's body, one gets to hear compliments like very nice, handsome, which can be a source of happiness, compared to someone who does not get to hear such things. The person himself, who owns the body and those who interact with his body, other people, both are part of the society, so here it is like considering others as a mirror and looking into it, the reaction of others becomes valuable here However, this includes one's spiritual values and standards, and the way of looking at oneself. Yet in today's materialistic age where success is at its peak, and the desire to make oneself more and more important and to see oneself at its peak, body image has become an important factor, which shows that if there is a feeling of satisfaction with one's body, then there is a glimpse of happiness, if not, then there is dissatisfaction. Where locomotor disabilities are already unique due to their physical differences, this area of research becomes important in such a situation as to how locomotor disabilities live their life in society with regard to their body image.

Body image, which reflects how people view, assess, and feel about their own bodies, is an essential component of psychological well-being.For individuals with locomotor disabilities, changes in physical appearance, posture, movement, and independence can significantly alter their body image. Locomotor disabilities, which affect the ability to walk or move freely, often result from conditions such as spinal cord injuries, amputations, cerebral palsy, or muscular disorders. These physical changes are not only functional but also visible, which can make individuals more vulnerable to negative social judgments and internalized stigma.

As a result, many people with locomotor disabilities experience challenges to their self-esteem and personal identity, sometimes feeling disconnected from their pre-disability body or

struggling with societal expectations of "normal" physicality. Negative body image in this population can contribute to psychological issues such as depression, anxiety, feelings of inferiority, and social isolation. On the other hand, positive adaptation to bodily changes and a healthy body image can enhance emotional resilience, self-acceptance, and quality of life. Understanding the impact of locomotor disability on body image is vital for creating psychological support systems, promoting inclusion, and guiding holistic rehabilitation efforts that address not just physical but also emotional recovery.

Body image represents an individual's subjective experience and cognitive-emotional appraisal of their own physical appearance and bodily function. In individuals with locomotor disabilities—resulting from conditions such as spinal cord injuries, amputations, neuromuscular disorders, or congenital abnormalities—these perceptions are often profoundly affected. Alterations in mobility, physical form, and visible bodily differences can lead to heightened body dissatisfaction and identity disturbance. The visibility of locomotor impairments frequently exposes individuals to societal stigma, negative stereotypes, and altered interpersonal interactions, which may exacerbate negative self-perceptions and emotional distress.

Research indicates that people with locomotor disabilities are at increased risk for developing negative body image, which is closely associated with psychological outcomes such as depression, anxiety, lowered self-esteem, and social withdrawal. However, positive body image and adaptive coping mechanisms have been shown to serve as protective factors, contributing to better psychological adjustment and enhanced overall well-being. Examining the influence of locomotor disability on body image is essential for informing clinical practices, designing comprehensive rehabilitation programs, and promoting psychosocial interventions aimed at fostering resilience and improving quality of life in this population.

Lower limb amputation is a significant life experience, according to Sabah et al.'s (2019) study Capabilities of Lower Limb Amputated Patients and Its Relation to Body Image and Depression.that significantly impacts an individual's physical, psychological, and social functioning. This study explored the relationship between motor capabilities, body image, and depression in lower limb amputees. A descriptive correlational design was used with a convenient sample of 64 adult male and female patients at the Minia University Hospital's Rheumatology and Rehabilitation Department. Event for gathering data involved a structured interview for demographic information and three standardized scales: the Beck Depression Inventory (BDI), Amputee Body Image Scale (ABIS), and Locomotor Capabilities Index (LCI).

The findings revealed that, six months after amputation, 31.2% of patients had moderate depression, 93.7% reported having a poor body image, and 73.5% had poor locomotor abilities. Body image and locomotor skills were shown to be strongly positively correlated,

whereas depression level and locomotor skills were found to be strongly negatively correlated.s. The study concludes that reduced functional abilities following lower limb amputation negatively influence both body image and mental health. It emphasizes the need for structured rehabilitation programs tailored to the physical and psychological needs of amputees.

Taleporos et al., (2002) stated in their study titled "Body image and physical disability—personal perspectives" that this study employed a qualitative research approach to explore body image issues among individuals with physical disabilities. The sample included seven participants — three males and four females — aged between 22 and 50 years, all residing in Melbourne, Australia. Among them, three identified as heterosexual, two as homosexual, and two described themselves as predominantly heterosexual with some bicurious tendencies. Data collection involved individual interviews lasting around two hours, during which participants answered a series of open-ended, pre-formulated questions. The findings revealed that physical impairments negatively affected participants' psychological well-being, emotions, and self-perception regarding their bodies. The significant role of social feedback in shaping body image was emphasized, and evidence suggested that, over time, individuals tend to adapt to their bodily changes and develop greater acceptance of their disabilities.

Durmus et al.,(2015) in their study titled "Psychiatric Symptoms in Male Traumatic Lower Limb Amputees: Associations with Neuropathic Pain, Locomotor Capabilities, and Perception of Body Image" stated that study aimed to assess the association between mental symptoms, functional status, and body image disturbances in male lower limb amputation (LLA) patients with and without neuropathic pain.A total of 50 male traumatic LLA patients participated in the study. Of these, 27 were diagnosed with neuropathic pain (Group 1), while 23 did not experience neuropathic pain (Group 2). Demographic information such as age, height, weight, and duration since amputation were gathered. The locomotor capacities index (LCI) and amputee body image scale (ABIS) scores of each participant were calculated. The Symptom Checklist-90-R, Beck Depression Inventory, Pittsburgh Sleep Quality Index, Rosenberg Self-Esteem Scale, State-Trait Anxiety Inventory, and Short Form 36 were among the psychological tests that participants also filled out.

Numerous psychiatric symptoms, including somatization, interpersonal sensitivity, depression, anxiety, anger-hostility, sleep length, quality, and disturbance, daytime drowsiness, trait anxiety, and quality of life, were shown to differ significantly between the two groups. (QOL). Group 1, which had neuropathic pain, showed significantly higher levels of these symptoms compared to Group 2. Additionally, significant correlations were found between the ABIS and LCI scores and the severity of psychiatric symptoms. The study concluded that psychiatric symptoms, beyond just depression and anxiety, may also be present in amputees with neuropathic pain. It was suggested that increasing physical activity and fostering a positive body image might help reduce the severity of psychiatric symptoms in this population.

“How has body image been evaluated among people with lower limb loss?” is the title of a study by Nugent et al. (2024). A scoping review focused on the dynamic and changing character of body image, highlighting the various ways it is defined and quantified in studies including people with lower limb loss (PWLLL). The majority of research employed the Amputee Body Image Scale (ABIS) to measure body image, and 41% of them cited a theoretical framework. Generally speaking, PWLLL groups reported a more negative body image than non-PWLLL groups; results varied depending on gender and the extent of amputation. The psychosocial effects of losing a limb, such as altered social interactions and functional capacities, were highlighted in qualitative research.

The review found that body image is often assessed using negative terminology, reflecting a pathology-driven approach commonly seen in clinical populations. It advocates for a neutral, inclusive discourse that challenges societal stigmas and promotes acceptance of altered body images.

The ABIS, though widely used, does not account for changes in body image over time, and future studies should validate body image scales specifically for PWLLL. Engaging in physical activities and supportive social groups can positively influence body image. The review also suggests that time since amputation and prosthesis experience are key factors in how PWLLL perceive their body, emphasizing the need for longitudinal studies to better understand body image over time during rehabilitation and reintegration.

Coping

Coping is the process through which individuals manage the psychological and emotional challenges that arise in response to stressors in their environment (Lazarus & Folkman, 1984). When people encounter situations that threaten their well-being, they often experience a range of emotional reactions such as anxiety, frustration, or sadness. Coping involves the strategies and actions they use to navigate these challenges in a way that preserves mental balance and promotes adaptation. These responses can be both conscious and unconscious, ranging from deliberate problem-solving to automatic emotional defenses (Folkman & Moskowitz, 2004).

Coping strategies are typically categorized into different types, such as problem-focused coping and emotion-focused coping. Problem-focused coping refers to efforts aimed at changing or eliminating the source of stress, such as seeking solutions, planning, or taking direct action (Lazarus & Folkman, 1984). Emotion-focused coping, on the other hand, involves managing the emotional distress that comes with the stressor, often through techniques like

seeking emotional support, reinterpreting the situation, or engaging in relaxation practices (Carver, 1997). While both approaches can be effective, their success often s contingent upon the type of stressor and the person s contingent upon the type of stressor and the person's personal resources (Folkman & Moskowitz, 2004).

The fact that coping is not a one-size-fits-all approach must be acknowledged. What works for one person in a given situation may not be effective for another. Cultural background, personality traits, previous experiences, and the availability of social support all influence how a person copes with adversity (Miller & Norman, 2004). Additionally, coping is a dynamic process that may evolve over time as situations change or as individuals gain new skills and perspectives (Bonanno, 2004).

Understanding how people cope with stress is essential for promoting psychological health and resilience. Effective coping strategies can reduce the negative impact of stress and support individuals in maintaining their well-being, while ineffective or maladaptive coping—such as avoidance, denial, or substance use—may lead to further psychological difficulties (Taylor, 2011). Therefore, learning about coping mechanisms can provide valuable insights for improving mental health, both at an individual and societal level (Folkman, 2013).

Coping is not only influenced by the nature of the stressor but also by individual and situational factors that shape how a person perceives and responds to challenges. Personality traits such as optimism, self-efficacy, and emotional regulation skills often enhance one's ability to cope effectively (Aspinwall & Taylor, 1997). Likewise, the availability of external resources, such as supportive relationships, access to mental health services, and a stable environment, can significantly improve coping outcomes (Cohen & Wills, 1985). In contrast, chronic stress, social isolation, or lack of control may hinder adaptive coping and increase vulnerability to mental health issues such as anxiety, depression, or burnout (Gomez & Aupperle, 2016). Recognizing the multidimensional nature of coping emphasizes the importance of personalized approaches in psychological support and intervention. By fostering adaptive coping skills through education, therapy, or community support, individuals can be better equipped to face life's inevitable stressors with resilience and confidence (Snyder et al., 2015).

Orthopedic disabilities, which may include conditions such as limb amputations, congenital skeletal disorders, or spinal cord injuries, can have a major effect on a person's social, psychological, and physical health. These challenges often create a continuous need for

adjustment in various life domains, including mobility, self-care, employment, and social interaction. Coping in this context involves the strategies individuals use to manage the emotional and practical consequences of their condition. Understanding how orthopedically handicapped individuals cope with their limitations is essential for developing effective psychological and rehabilitative interventions.

Individuals with orthopedic disabilities often face a complex combination of physical restrictions and societal barriers. Physical limitations can lead to a loss of independence and reduced access to resources and services. At the same time, social stigma, discrimination, and lack of accessibility can contribute to feelings of exclusion, helplessness, and lowered self-worth (Shakespeare, 2014). These challenges may be further compounded by secondary health issues, such as chronic pain or comorbid mental health conditions, which increase the psychological burden.

Coping strategies used by orthopedically handicapped individuals generally fall into two groups: emotion-focused coping and problem-focused coping. Coping with problems entails taking active steps to manage or modify the source of stress. This may include learning to use assistive technologies, engaging in physical rehabilitation, modifying one's environment, or developing new routines for independence (Livneh & Antonak, 2005). Emotion-focused coping, on the other hand, helps individuals regulate the emotional distress associated with their condition. This may involve seeking social support, engaging in spiritual or mindfulness practices, or reframing the situation in a more positive light (Smedema et al., 2014).

The availability and quality of social support significantly influence coping outcomes. Strong support networks—comprising family, peers, counsellors, or healthcare professionals—can provide both emotional reassurance and practical assistance. Individuals with higher emotional intelligence and resilience are also more likely to employ adaptive coping mechanisms, which promote better psychological well-being (Papadopoulos et al., 2013).

Effective coping plays a critical role in psychosocial adjustment, which refers to how well an individual adapts emotionally and socially to life with a disability. Research shows that people who accept their disability and actively engage in adaptive behaviors report higher life satisfaction and fewer depressive symptoms (Coffey et al., 2009). On the contrary, maladaptive coping strategies, such as avoidance, denial, or substance use, are associated with poorer psychological outcomes and lower levels of functioning.

Jaiswal and colleauges (2016) did a study on “Stress and coping mechanism among normal and orthopedically impaired early adolescents” and they concluded that the psychological well-being of adolescents with orthopedic impairments has been a subject of considerable research. A study conducted in Allahabad city compared stress levels and coping

mechanisms between two groups: 50 normal adolescents and 50 orthopedically impaired adolescents. The participants were selected from Viklang Kendra, Allahabad, and the study aimed to assess the differences in stress and coping strategies between these groups. The findings revealed that orthopedically impaired adolescents experienced higher levels of stress compared to their normal counterparts. This heightened stress was attributed to various factors, including physical limitations and societal challenges. In terms of coping mechanisms, the study found that normal adolescents tended to adopt more realistic approaches to managing frustration, whereas orthopedically impaired adolescents employed different strategies to cope with their stressors. These results underscore the importance of understanding the unique stressors faced by orthopedically impaired adolescents and the coping strategies they utilize. Such insights are crucial for developing targeted interventions and support systems to enhance their psychological well-being.

Quality of life

Quality of life is defined by the World Health Organization's Quality of Life (WHOQOL) initiative as people's perception of their position in life in relation to their goals, expectations, standards, and concerns, as well as the culture and value systems in which they live. Using objective variables including safety, health, housing, education, and recreational activities, the social objective model defines quality of life (Schalock, 1994). According to the World Health Organization (WHO), quality of life (QOL) is an essential indication of health status for various populations, such as those with cerebral palsy (World Health Organization, 1993; Dickinson et al., 2007).
Physical Disability (PD) may affect the quality of Physical Disability of life by causing stress, despair, pessimism, isolation, and a sense of reliance, all of which can contribute to poor adaption to regular social life (Patrick et al., 1986; Harker et al., 2002; Anke & Fugl-Meyer, 2003; Giacobbi et al., 2008). Several studies have found that adolescents with Parkinson's disease developed with varying restrictions in physical function, participation in school and community activities, social adjustment, and psychosocial function (Stevens et al., 1996; Kim & Kang, 2003; Edwards et al., 2003).

Numerous cross-sectional studies on how people estimate their own quality of life have been conducted. According to these research, (i) physical limitations do not always result in lower levels of happiness and satisfaction with quality of life (Lin et al., 2009); and (ii) there was no discernible relationship between subjective and objective overall QOL scores (Ju et al., 2006). Additional research showed that personal adaptation and a supportive environment could be important indicators of improved quality of life for persons with motor impairments (Lin et al., 2009; Ju et al., 2006). General self-esteem was the most important factor in explaining the variation in perceived QOL among women with and without impairments. Among women with physical limitations, marital status explained a considerable portion of the variation in perceived QOL. In cases when general self-esteem levels were comparable,

married women with physical limitations had a higher perceived QOL score than unmarried women. For women with impairments, good QOL meant the ability to operate in all aspects of life, including starting a family. These perceptions are based on past experiences and a lack of current opportunities to form personal relationships (Aloni & Heroti, 2002). There was no moderating influence of marital status on the relationship between subjective self-worth and quality of life among healthy women (Araten-Bergman & Rimmerman, 2009).

According to certain studies, women with disabilities had significantly lower quality of life and self-esteem than women without disabilities (Nosek et al., 2003; Livneh & Antonak, 1997).

Researchers investigated the quality of life of people with disabilities and concluded that regardless of the degree of the handicap, a person with a disability who was able to manage daily chores, challenges, and responsibilities, such as those linked to work or school, had a higher quality of life (QOL) (Krause & Viemero, 1998).As a result, while disability can limit functioning and social participation, it does not always lead to a reduced quality of life (Bent et al., 2001).

Young people with impairments are at significant risk of getting secondary disabilities as adults (Marge, 1988). Secondary disabilities, frequently connected with unhealthy lifestyle, such as heart disease, respiratory issues, and emotional difficulties, which can lead to further declines in quality of life (QOL). (Patrick et. al. 1986; Levasseur et. al. 2004; Benavente-Aguilar et. al. 2004).

According to earlier studies, (i) schoolgirls growing through adolescence perceived their own health to be worse than that of schoolboys (Cavallo et al. 2006); (ii) QOL appears to decline with age among older primary and younger secondary school students (Chow et al. 2005); and (iii) satisfaction reported by students with mild mental disabilities appeared to be associated with education placement (Brantley et al. 2002).

Emotional Abuse

Compared to other types of abuse like physical or sexual abuse, emotional abuse is a prevalent kind of maltreatment that can have significant and enduring impacts on people. However, it is frequently less acknowledged and understood. Emotional abuse causes psychological wounds that may go unseen by others, including the victims themselves, in contrast to physical violence, which leaves noticeable scars. Emotional abuse is subtle and sneaky, making it hard to identify and deal with. As a result, it continues in a variety of interpersonal connections, including romantic relationships, parent-child dynamics, and institutions like organizations and schools.

There isn't a clear-cut definition of emotional abuse. More specifically, according to Renzetti and Follingstad (2017), emotional abuse is defined as "pain or withdrawal, humiliation, disruption of communication, isolation, and other psychologically abusive tactics and behaviour." According to reports, one of the most widely used expressions in society today is "emotional abuse." In 1996, the US Department of Justice and Health Canada contended that emotional abuse is any form of fear brought on by intimidation, isolation, threats, gaslighting, or insults used towards one another in an attempt to get control and power (Follingstad, et al, 2015). The goal of emotional abuse is to exert control over another person, but the abuser does not turn to physical violence or beatings. Previously research has clearly shown that emotional abuse has negative effects on the person experiencing it. It might not be acknowledged, particularly in the case of youngsters. Intimate relationships, families, and workplaces are all susceptible to emotional abuse (Fears et al., 2018).

Intentional or unintentional repeating behaviour patterns over time might be considered emotional abuse. An individual's integrity and sense of self-worth are impacted by emotional maltreatment (Capaldi et al., 2012). Terms like verbal abuse, psychological cruelty, intimate fear, and psychological violence are synonymous with psychological abuse. Historically, researchers have seen emotional abuse as the result Several additional types of abuse, mostly sexual or physical,and have not examined it independently (Arias & Pape 1999). Additionally, according to several studies, victims of frequent high-emotional abuse endure far more suffering and harm than those who face occasional physical attacks (Frieze & Davis, 2002).

Heim et al. (2013) state that emotional abuse is thought to be the most severe type of misbehaviour because it harms the developing brains of children, affecting both their mental and physical wellness, in addition to their cognitive and social development (Heim et al., 2013). "Persistent or extreme thwarting of the child's basic emotional needs [such as] parental acts that are harmful because they are insensitive to the child's development level" is what Cicchetti, (1993) defined as emotional abuse. Emotional abuse harms the nervous system as well as lowers feelings of worth. Emotional abuse changes some regions of the brain, especially those involved with detecting and directing emotions, as well as recognizing and reacting to the feelings of others. Those who claim emotional abuse have mood swings, sorrow, anxiousness, inadequate self-worth, and powerful or suppressed emotional reactions (Heim et al., 2013).

Rationale of the Study

Locomotor-disabled individuals often face numerous challenges in their daily lives, not only due to physical limitations but also because of societal attitudes and discrimination. Among these challenges, gender inequality remains a critical yet underexplored issue. Men and women with disabilities may experience unequal treatment, limited access to opportunities, and differing psychological impacts due to both their gender and disability status.

This study aims to explore the psychological factors associated with perceptions and experiences of gender equality among locomotor-disabled persons. Variables such as emotional abuse, coping strategies, emotional abuse, body image, and quality of life are central to understanding how gender-related dynamics influence their mental and emotional well-being. By identifying these psychological correlates, the study will help reveal how gender equality (or the lack of it) shapes their lived experiences.

Understanding these relationships is vital for developing inclusive policies, mental health support systems, and empowerment programs that promote equality, dignity, and participation for all genders within the disabled community. This research, therefore, contributes to building a more equitable and psychologically supportive environment for locomotor-disabled individuals. The main benefit of this research will be to understand and solve the problems of the lives of locomotor disabled people in a better way and to make better policies to increase positivity in life.

Objectives of the study

1. To study the relationship between Gender Equality and body image among groups of persons made on the basis of gender and disability.
2. To study the relationship between Gender Equality and Coping Modes among groups of persons made on the basis of gender and disability.
3. To study the relationship between Gender Equality and quality of life among groups of persons made on the basis of gender and disability.
4. To study the relationship between Gender Equality and emotional abuse among groups of persons made on the basis of gender and disability.
5. To study the relationship between Gender Equality and acceptance of disability among groups of persons made on the basis of gender and disability.
6. To study the Gender differences on the variable of Gender equality among groups of persons made on the basis of gender and disability.

7. To study the Gender differences on the variable of body image among groups of persons made on the basis of gender and disability.
8. To study the Gender differences on the variable of coping modes among groups of persons made on the basis of gender and disability.
9. To study the Gender differences on the variable of emotional abuse among groups of persons made on the basis of gender and disability.
10. To study the Gender differences on the variable of acceptance of disability among groups of persons made on the basis of gender and disability.

Research hypotheses of the study

1 There will be significant relationship between Gender Equality and body image among groups of persons made on the basis of gender and disability.
2 There will be significant relationship between Gender Equality and Coping Modes among groups of persons made on the basis of gender and disability.
3 There will be significant relationship between Gender Equality and quality of life among groups of persons made on the basis of gender and disability.
4 There will be significant relationship between Gender Equality and emotional abuse among groups of persons made on the basis of gender and disability.
5 There will be significant relationship between Gender Equality and acceptance of disability among groups of persons made on the basis of gender and disability.
6 There will be significant Gender differences on the variable of Gender equality among groups of persons made on the basis of gender and disability.
7 There will be significant Gender differences on the variable of body image among groups of persons made on the basis of gender and disability.
8 There will be significant Gender differences on the variable of coping modes among groups of persons made on the basis of gender and disability.
9 There will be significant Gender differences on the variable of emotional abuse among groups of persons made on the basis of gender and disability.
10 There will be significant Gender differences on the variable of acceptance of disability among groups of persons made on the basis of gender and disability.

Methodology

Sample size

A total of 480 persons between 18 and 50 years of age will be sampled, out of which 320 will be locomotor disabled and 160 will be normal individuals. The data will be divided in below mentioned categories:

	Normal Persons without Disability	Persons with 40 to 60 % disability	Persons with 61 to 80 % disability
Males	80	80	80
Females	80	80	80

Sources of sample collection

1. PGI
2. Government Civil Hospital
3. Red Cross Society
4. Disabled Welfare Agencies /Committee
5. State educational institutions of Haryana.
6. Government and Private Educational Institutes.

Criteria for inclusion

1. Such locomotor disabled persons whose disability is permanent in nature.
2. Those that have a medical certificate of their disability/UDID
3. Those whose disability percentage is in the range of 40 - 80.
4. Those whose age is between 18 to 50.
5. Those who can read, speak and understand Hindi and English.

Exclusion criteria

1. Those with locomotor disabilities whose disability is temporary in nature.
2. Those who do not have a medical certificate of their disability/UDID

3. Those whose disability percentage does not fall in the range of 40 - 80.

4. Those whose age does not fall between 18 to 50.

5. Those who cannot read speak or understand Hindi and English.

Tools description

1. **Gender Equality:** It will be measured by Gender role attitude scale (GRAS, 2011) given by Simge ZEYNELOöLU, Füsun TERZø2öLU .This scale contains 38 items and five dimensions (egalitarian gender roles, female gender roles, marriage gender roles, traditional gender roles and male gender roles). The instrument's total Cronbach's alpha internal consistency coefficient was found to be 0.92. The findings that were obtained showed that the survey is a valid and reliable instrument.
2. **Acceptance of disability (AD**) Linkowski (1971) : This scale will be applied on persons with disability only and not on the normal persons due to the nature of the scale. The present scale was developed by Donald C. Linkowski, Ph.D. The presented scale has 50 items. For all 50 items, 6 points have been written and six options have been given according to the scale. The following is the scoring methodology: Assign the following numerical values to the six-point scale for items 1, 4, 7, 10, 12, 13, 14, 16, 21, 24, 30, 34, 42, 48, and 50. (1) I disagree very much (4) I agree a little (2) I disagree pretty much (3) I disagree a little(5) I agree pretty much (6) I agree very much 2. Assign the following numerical values to the six-point scale for every other item: (6) I disagree very much (3) I agree a little (5) I disagree pretty much (2) I agree pretty much (4) I disagree a little (1) I agree very much
3. **Body Image Scale (BIS, Tani & Behmani, 2018)** The scale has been created by Tani and Behmani which has a total of 28 items. This scale is based on a 5-point Likert scale. For each item, five options are given respectively 1. Completely disagree 2. Disagree 3. Can't say anything 4. Agree 5. Completely agree. All the 5 dimensions of this scale and their reliability are as follows: 1. Wait perception (.90) 2. Wish for fit body (.78) 3. Satisfaction with body (.70) 4. Body part dissatisfaction (.81) 5. Health consciousness (.76). The overall test-retest reliability of this test is (.88)
4. **The Medical Coping Modes Questionnaire (Feifel, Strack, & Nagy (1987):** As originally conceived by Feifel, Strack, and Nagy (1987), the MCMQ is a 19-item

questionnaire that purports to measure the extent to which patients use three cognitive–behavioral coping strategies (Confrontation, Avoidance, and Acceptance–Resignation) in dealing with their illness. Each item is scored using a 4-point Likert rating that ranges from 1 = *never* to 4 = *very much*. Regarding the psychometric properties of the MCMQ, Feifel et al. (1987a) and others (e.g., Ashby & Lenhart, 1994; Lenhart & Ashby, 1996) reported moderate to high alpha coefficients (.56–.74) for the three subscales.

5. **WHOQOL** The presented scale was developed by the World Health Organization and has a total of 100 items. For all 100 items, five options are given for selection according to the five-point Likert scale. These 100 items mainly measure 6 dimensions respectively 1. Physical Capacity 2. Psychological 3. Level of Independence 4. Social Relationships 5. Environment 6. Spirituality/ Religion/ Personal Beliefs. Overall test-retest reliability is .78 and overall reliability is .84. The main purpose of the presented test is to measure the quality of life.
6. **Emotional Abuse Questionnaire (Momtaz et al., 2020)** The Questionnaire consists of 30 items and six subscales: Verbal abuse, Emotional rejection, Overcontrol, Insufficient control, over-expectation and Terrorizing. The scale consists of 5-point Likert scale responses of Always to Never. Scoring will be done as "4 = Always, 3 = Often, 2 = occasionally, 1 = rarely, 0 = Never". There are 30 items of which 8 (1,2,3,7,11,12,17,21) are designated for Verbal Abuse, 3 (13, 22, 28) for Emotional Rejection, 7 (4, 5, 14, 15, 23, 25, 30) for Over control, 5 (6, 8, 16, 18, 26) for Insufficient control, 3 (9, 19, 27) for Over-expectations and 4 (10, 20, 24, 29) for Terrorizing. The internal consistency (Cronbach's alpha) of the sub-scales as found by the developers of the tool was 0.87, 0.81, 0.83, 0.75, 0.77 and 0.84 respectively. The Total reliability of the questionnaire was evaluated by Cronbach's α and it was 0.93.

Procedure

This research study will be done by going to the participants will first be informed about the questionnaire and the standards, their consent will be taken for participating in the research, they will be taken into confidence, only those who meet the criteria set for participating in the research will be asked to fill the questionnaire, the conclusion of the data obtained from the questionnaire will be made through critical research analysis. Further after developing the rapport, online and offline both methods will be used for data collection.

Statistical Analysis

Inferential Statistics

Correlation

ANOVA

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